

## STATEMENT OF EMERGENCY

907 KAR 1:025E

(1) This emergency administrative regulation is being promulgated to establish the inflation factor for the period beginning January 1, 2006 and ending June 30, 2006 in order to enhance recipient access to services provided by an intermediate care facility for individuals with mental retardation or a developmental disability and to enable the Department for Medicaid Services (DMS) to adjust a facility's reimbursement if the facility experiences a mandated displacement of residents. Failure to enact this administrative regulation on an emergency basis would pose an imminent threat to the safety and welfare of Medicaid recipients whose receipt of services may be otherwise jeopardized.

(2) This emergency administrative regulation differs from the emergency administrative regulation governing the same subject that was filed December 30, 2004 in that it enables DMS to adjust a facility's reimbursement if the facility experiences a mandated displacement of residents and in that it establishes the inflation factor for the period beginning January 1, 2006 and ending June 30, 2006.

(3) This emergency administrative regulation shall be replaced by an identical ordinary administrative regulation filed with the Regulations Compiler.

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Ernie Fletcher  
Governor

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James W. Holsinger, Jr. M.D., Secretary  
Cabinet for Health and Family Services

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Long Term Care and Community Alternatives

4 (Emergency Amendment)

5 907 KAR 1:025E Payment for services provided by an intermediate care facility  
6 for individuals with mental retardation or a developmental disability, a dually-licensed  
7 pediatric facility, an institution for mental diseases, or a nursing facility with an all-  
8 inclusive rate unit.

9 RELATES TO: KRS 142.363, 42 C.F.R. Parts 430, 431, 432, 433, 435, 440,  
10 441, 442, 447, 455, 456, 42 U.S.C. 1396a, b, c, d, g, i, l, n, o, p, r, r-2, r-3, r-5, s

11 STATUTORY AUTHORITY: KRS 142.363(3), 194A.030(2), 194A.050(1),  
12 205.520(3)[, ~~EO-2004-726~~

13 NECESSITY, FUNCTION, AND CONFORMITY: [~~EO-2004-726, effective July 9,~~  
14 ~~2004, reorganized the Cabinet for Health Services and placed the Department for~~  
15 ~~Medicaid Services and the Medicaid Program under the Cabinet for Health and Family~~  
16 ~~Services.~~] The Cabinet for Health and Family Services, Department for Medicaid  
17 Services has responsibility to administer the Medicaid Program. KRS 205.520(3)  
18 authorizes the cabinet by administrative regulation, to comply with any requirement that  
19 may be imposed, or opportunity presented, by federal law for the provision of medical  
20 assistance to Kentucky's indigent citizenry. This administrative regulation establishes  
21 the method for determining amounts payable by the Medicaid Program for nursing

1 facility services provided by an intermediate care facility for individuals with mental  
2 retardation or a developmental disability, a dually-licensed pediatric facility, an institution  
3 for mental diseases, or a nursing facility with an all-inclusive rate unit.

4 Section 1. Definitions.

5 (1) "Allowable cost" means that portion of a facility's cost which may be allowed  
6 by the department in establishing the reimbursement rate.

7 (2) "Calculated rate" means the rate effective July 1, 1999 and each July 1  
8 thereafter for:

9 (a) An intermediate care facility for individuals with mental retardation or a  
10 developmental disability (ICF-MR-DD); or

11 (b) A nursing facility certified as:

12 1. A dually-licensed pediatric facility; or

13 2. An institution for mental diseases.

14 (3) "Cost-based facility" means a facility which:

15 (a) The department shall reimburse for all allowable costs; and

16 (b) Is either:

17 1. A dually-licensed pediatric facility;

18 2. An intermediate care facility for individuals with mental retardation or a  
19 developmental disability; or

20 3. An institution for mental diseases.

21 (4) "Cost report" means Cost-based Facility Reimbursement Cost Report  
22 Instructions and Cost-based Facility Reimbursement Cost Report.

23 (5) "Department" means the Department for Medicaid Services or its designee.

1 (6) "DRI" means an indication of changes in health care costs from year to year  
2 developed by Data Resources Incorporated.

3 (7) "IMD" means an institution for mental diseases, excluding psychiatric  
4 hospitals.

5 (8) "Nursing facility" or "NF" means that:

6 (a) The state survey agency has:

7 1. Granted an NF license to a facility; and

8 2. Recommended the NF to the department for certification as a Medicaid  
9 provider; and

10 (b) The department has granted certification for Medicaid participation to the NF.

11 (9) "Occupancy factor" means a percentage representing:

12 (a) A facility's actual occupancy level; or

13 (b) A minimum occupancy level assigned to a facility if its occupancy level is  
14 below the minimum level established in Section 3(17) of this administrative regulation.

15 (10) "Prospective rate" means a payment rate for routine services based on  
16 allowable costs and other factors which, except as specified in Section 3[(14)] of this  
17 administrative regulation, shall not be retroactively adjusted, either in favor of the facility  
18 or the department.

19 (11) "Routine services" means services covered by the Medicaid Program  
20 pursuant to 42 C.F.R. 483.10(c)(8)(i).

21 (12) "State survey agency" means the Cabinet for Health and Family Services,  
22 Office of Inspector General, Division of Long-term Care.

23 Section 2. Certified Bed Requirements. Except for an intermediate care facility

for individuals with mental retardation or a developmental disability or a nursing facility with an all-inclusive rate unit, a facility which desires to participate in the Medicaid Program shall comply with the following requirements:

(1) If the facility has less than ten (10) beds, all of its beds shall participate in the Medicare Program; or

(2) If the facility has ten (10) or more beds, it shall be required to have the greater of:

(a) Ten (10) of its Medicaid-certified beds participating in the Medicare Program; or

(b) Twenty (20) percent of its Medicaid-certified beds participating in the Medicare Program.

Section 3. Payment System for a Cost-based Facility. The department's reimbursement system shall include the specific policies, components or principles established in this section.

(1)(a) Prospective payment rates for routine services shall be set by the department on a facility-specific basis, and shall not be subject to retroactive adjustment except as specified in this section of this administrative regulation.

(b) Prospective rates shall be determined on a cost basis annually, and may be revised on an interim basis by the department.

(c) An adjustment to a prospective rate (subject to the maximum payment for that type of facility) shall be considered if:

1. The facility's increased costs are attributable to:

a. A governmentally imposed minimum wage increase, ~~or a~~ staffing ratio

1 increase, or a mandated level of service increase; and

2 b. The increase was not included in the DRI; [øf]

3 2. A new licensure requirement or new interpretation of an existing requirement  
4 by the appropriate governmental agency as issued in an administrative regulation  
5 results in changes that affect all facilities within the class; or

6 3. The facility experiences a mandated displacement of residents.

7 (d)1. The amount of any prospective rate adjustment resulting from a  
8 governmentally imposed minimum wage increase or licensure requirement change or  
9 interpretation as cited in subparagraph 2 shall not exceed the amount by which the cost  
10 increase resulting directly from the governmental action exceeds on an annualized  
11 basis the inflation allowance amount included in the prospective rate for the general  
12 cost area in which the increase occurs. For purposes of this determination, costs shall  
13 be classified into the following two (2) general areas:

14 a. Salaries; and

15 b. Other.

16 2. The effective date of an interim rate adjustment shall be the first day of the  
17 month in which the adjustment is requested or in which the cost increase occurred,  
18 whichever is later.

19 (2)(a) The state shall set a uniform rate year for a cost-based facility (July 1 -  
20 June 30) by taking the latest available cost data available as of May 16 of each year  
21 and trending the facility costs to July 1 of the rate year. If the latest available cost report  
22 data has not been audited or desk-reviewed prior to rate setting for the universal year  
23 beginning July 1, a prospective rate based on a cost report which has not been audited

1 or desk-reviewed shall be subject to adjustment when the audit or desk review is  
2 completed.

3 (b) Partial year, or budget cost data shall be used if a full year's date is  
4 unavailable. Unaudited reports shall be subject to an adjustment to the audited amount.

5 (c) Other factors relating to costs.

6 1. If the department has made a separate rate adjustment as compensation to a  
7 facility for a minimum wage update, the department shall:

8 a. Not pay the facility twice for the same costs; and

9 b. Adjust downward the trending and indexing factors to the extent necessary to  
10 remove from the factors costs relating to the minimum wage updates already provided  
11 for by the separate rate adjustment.

12 2. If the trending and indexing factors include costs related to a minimum wage  
13 increase:

14 a. The department shall not make a separate rate adjustment; and

15 b. The minimum wage costs shall not be deleted from the trending and indexing  
16 factors.

17 3. The maximum payment amounts for the prospective universal rate year shall  
18 be adjusted each July 1 so that the maximum payment amount in effect for the rate year  
19 shall be related to the cost reports used in setting the facility rates for the rate year.

20 4. For purposes of administrative ease in computations, normal rounding shall be  
21 used in establishing the maximum payment amount, with the maximum payment  
22 amount rounded to the nearest five (5) cents.

23 (3)(a) Except as provided in paragraph (b) of this subsection, interest expense

1 used

2 in setting a prospective rate shall be an allowable cost if permitted pursuant to 42 C.F.R.

3 413.153 and if the interest expense:

4 1. Represents interest on:

5 a. Long term debt existing at the time the provider enters the program; or

6 b. New long-term debt, if the proceeds are used to purchase fixed assets relating  
7 to the provision of the appropriate level of care.

8 (i) If the debt is subject to variable interest rates found in balloon-type financing,  
9 renegotiated interest rates shall be allowable; and

10 (ii) The form of indebtedness may include mortgages, bonds, notes, and  
11 debentures if the principal is to be repaid over a period in excess of one (1) year; or

12 2. Is for working capital and operating needs that directly relate to providing  
13 patient care. The form of indebtedness may include notes, advances and various types  
14 of receivable financing.

15 (b) Interest on a principal amount used to purchase goodwill or other intangible  
16 assets shall not be considered an allowable cost.

17 (4) The allowable cost for a service or good purchased by a facility from a related  
18 organization shall be the cost to the related organization, unless it can be demonstrated  
19 that the related organization is equivalent to a second party supplier.

20 (a) Except as provided in paragraph (b) of this subsection, an organization shall  
21 be considered a related organization if an individual possesses five (5) percent or more  
22 of ownership or equity in the facility and the supplying business.

23 (b) An organization shall not be considered a related organization if fifty-one (51)

1 percent or more of the supplier's business activity of the type carried on with the facility  
2 is transacted with persons and organizations other than the facility and its related  
3 organizations.

4 (5)(a) Except as provided in paragraph (b) of this subsection, the amount  
5 allowable for leasing costs shall not exceed the amount which would be allowable  
6 based on the computation of historical costs.

7 (b) The department shall determine the allowable costs of an arrangement based  
8 on the costs of the original lease agreement if:

9 1. A cost-based facility entered into a lease arrangement as an intermediate care  
10 facility prior to April 22, 1976;

11 2. An intermediate care facility for individuals with mental retardation or a  
12 developmental disability entered into a lease arrangement prior to February 23, 1977; or

13 3. A nursing facility entered into a lease arrangement as a skilled nursing facility  
14 prior to December 1, 1979.

15 (6) A cost shall be allowable and eligible for reimbursement if the cost is:

16 (a) Reflective of the provider's actual expenses of providing a service; and

17 (b) Related to Medicaid patient care pursuant to 42 C.F.R. 413.9.

18 (7) The following costs shall be allowable:

19 (a) Costs to related organizations pursuant to 42 C.F.R. 413.17;

20 (b) Costs of educational activities pursuant to 42 C.F.R. 413.85;

21 (c) Research costs pursuant to 42 C.F.R. 413.90;

22 (d) Value of services of nonpaid workers pursuant to 42 C.F.R. 413.94;

23 (e) Purchase discounts and allowances, and refunds of expenses pursuant to 42

1 C.F.R. 413.98;

2 (f) Depreciation on buildings and equipment if a cost is:

3 1. Identifiable and recorded in the provider's accounting records;

4 2. Based on historical cost of the asset or, if donated, the fair market value; or

5 3. Prorated over the estimated useful life of the asset using the straight-line  
6 method;

7 (g) Interest on current and capital indebtedness; or

8 (h) Professional costs of services of full-time or regular part-time employees not  
9 to exceed what a prudent buyer would pay for comparable services.

10 (8) The following shall not be allowable costs:

11 (a) The value of services provided by nonpaid members of an organization if  
12 there is an agreement with the provider to furnish the services at no cost;

13 (b) Political contributions;

14 (c) Legal fees for unsuccessful lawsuits against the Cabinet for Health and  
15 Family Services;

16 (d) Travel and associated costs outside the Commonwealth of Kentucky to  
17 conventions, meetings, assemblies, conferences or any related activities that are not  
18 related to NF training or educational purposes; or

19 (e) Costs related to lobbying.

20 (9) To determine the gain or loss on the sale of a facility for purposes of  
21 determining a purchaser's cost basis in relation to depreciation and interest costs, the  
22 following methods shall be used for changes of ownership occurring before July 18,  
23 1984:

1 (a)1. Determine the actual gain on the sale of the facility; and

2 2. Add to the seller's depreciated basis two-thirds (2/3) of one (1) percent of the  
3 gain for each month of ownership since the date of acquisition of the facility by the seller  
4 to arrive at the purchaser's cost basis;

5 (b) Gain shall be the amount in excess of a seller's depreciated basis as  
6 computed  
7 under program policies at the time of a sale, excluding the value of goodwill included in  
8 the purchase price;

9 (c) A sale shall be any bona fide transfer of legal ownership from an owner to a  
10 new owner for reasonable compensation, which shall usually be fair market value. A  
11 lease purchase agreement or other similar arrangement which does not result in a  
12 transfer of legal ownership from the original owner to the new owner shall not be  
13 considered a sale until legal ownership of the property is transferred; and

14 (d) If an enforceable agreement for a change of ownership was entered into prior  
15 to July 18, 1984, the purchaser's cost basis shall be determined pursuant to paragraphs  
16 (a) through (c) of this subsection.

17 (10) Valuation of capital assets.

18 (a) An increase in valuation in relation to depreciation and interest costs shall not  
19 be allowed for changes of ownership occurring after July 18, 1984 and before October  
20 1, 1985.

21 (b) For bona fide changes of ownership entered into on or after October 1, 1985,  
22 the depreciation and interest costs shall be increased in valuation in accordance with 42  
23 U.S.C. 1395x(v)(1)(O)(i).

1 (11)(a) A facility shall maintain and make available any records and data  
2 necessary to justify and document:

- 3 1. Costs to the facility; and
- 4 2. Services performed by the facility; and

5 (b) The department shall have unlimited on-site access to all of a facility's fiscal  
6 and service records for the purpose of:

- 7 1. Accounting;
- 8 2. Auditing;
- 9 3. Medical review;
- 10 4. Utilization control; and
- 11 5. Program planning.

12 (12) The following shall apply to an annual cost report:

13 (a) A year-end cost report shall contain information relating to prior year cost, and  
14 shall be used in establishing prospective rates and setting ancillary reimbursement  
15 amounts;

16 (b) A new item or expansion representing a departure from current service levels  
17 for which the facility requests prior approval by the department shall be so indicated with  
18 a description and rationale as a supplement to the cost report;

19 (c) Department approval or rejection of a projection or expansion shall be made  
20 on a prospective basis in the context that if an expansion and related costs are  
21 approved they shall be considered when actually incurred as an allowable cost.  
22 Rejection of an item or costs shall represent notice that the costs shall not be  
23 considered as part of the cost basis for reimbursement. Unless otherwise specified,

1 approval shall relate to the substance and intent rather than the cost projection; and

2 (d) If a request for prior approval of a projection or expansion is made, absence  
3 of a response by the department shall not be construed as approval of the item or  
4 expansion.

5 (13)(a) The department shall perform a desk review of each year-end cost report  
6 and ancillary service cost to determine the necessity for and scope of an audit in  
7 relation to routine and ancillary service cost;

8 (b) If a field audit is not determined to be necessary, the cost report shall be  
9 settled without an audit;

10 (c) A desk review or field audit shall be used for purposes of verifying cost to be  
11 used in setting the prospective rate or for purposes of adjusting prospective rates which  
12 have been set based on unaudited data; and

13 (d) Audits may be conducted annually or at less frequent intervals.

14 (14) A year-end adjustment of the prospective rate and a retroactive cost  
15 settlement shall be made if:

16 (a) An incorrect payment has been made due to a computational error (other  
17 than an omission of cost data) discovered in the cost basis or establishment of the  
18 prospective rate;

19 (b) An incorrect payment has been made due to a misrepresentation on the part  
20 of a facility (whether intentional or unintentional);

21 (c) A facility is sold and the funded depreciation account is not transferred to the  
22 purchaser; or

23 (d) The prospective rate has been set based on unaudited cost reports and the

1 prospective rate is to be adjusted based on audited reports with the appropriate cost  
2 settlement made to adjust the unaudited prospective payment amounts to the correct  
3 audited prospective payment amounts.

4 (15) A facility shall provide the services mandated in 42 C.F.R. 483.10(c)(8)(i).

5 (16) A facility shall submit to the department the data required for determining the  
6 prospective rate no later than sixty (60) days following the close of the facility's fiscal  
7 year. This time limit may be extended at the specific request of the facility with the  
8 department's concurrence.

9 (17) Allowable prior year cost, trended to the beginning of the rate year and  
10 indexed for inflation, shall be subject to adjustment based on a comparison of costs with  
11 a facility's occupancy factor.

12 (a) An occupancy factor shall not be less than actual bed occupancy, except that  
13 it shall not exceed ninety-eight (98) percent of certified bed days (or ninety-eight (98)  
14 percent of actual bed usage days, if more, based on prior year utilization rates).

15 (b) Except for a state-owned facility, a minimum occupancy factor shall be ninety  
16 (90) percent of certified bed days for facilities with less than ninety (90) percent certified  
17 bed occupancy.

18 (c) A minimum occupancy factor for a state-owned facility shall be seventy (70)  
19 percent of certified bed days.

20 (d) The department may impose a lower occupancy factor for a newly  
21 constructed or newly participating facility, or for an existing facility suffering a patient  
22 census decline as a result of a newly constructed or opened competing facility serving  
23 the same area.

(e) The department may impose a lower occupancy factor during the first two (2) full fiscal years an existing cost-based facility participates in the program under this payment system.

(18) A provider tax on a cost-based facility shall be considered an allowable cost.

(19) All other costs shall be:

(a) Other care-related costs;

(b) Other operating costs;

(c) Capital costs; or

(d) Indirect ancillary costs.

(20) Basic per diem costs for each major cost category (nursing services costs and all other costs) shall be the calculated rate arrived at after otherwise allowable costs are trended and adjusted in accordance with the:

(a) DRI inflation factor; and

(b) Occupancy factor.

(21) The DRI inflation factor applied to an ICF-MR-DD for the period beginning January 1, 2006 and ending June 30, 2006 ~~[January 1, 2005 and ending June 30, 2005]~~

shall be increased an additional six and eight-tenths (6.8) percent.

(22) Maximum allowable costs shall be the maximum amount which may be allowed to a facility as reasonable cost for the provision of a supply or service while complying with limitations expressed in related federal or state regulations.

(23) Nursing services costs shall be the direct costs associated with nursing services.

1           Section 4. Prospective Rate Computation for a Cost-based Facility. The  
2 prospective rate for a cost-based facility shall reflect the following:

- 3           (1) The adjusted allowable cost for the facility; and
- 4           (2) Occupancy factor.

5           Section 5. Ancillary Services.

6           (1) Except for an intermediate care facility for individuals with mental retardation  
7 or a developmental disability, an ancillary service shall be a direct service for which a  
8 charge is customarily billed separately from a per diem rate including:

9           (a) Ancillary services pursuant to 907 KAR 1:023; or

10          (b) Laboratory procedures or x-rays if ordered by a:

11          1. Physician;

12          2. An advanced registered nurse practitioner (ARNP) if the laboratory test or x-  
13 ray is within the scope of the ARNP's practice; or

14          3. Physician assistant if:

15          a. Authorized by the supervising physician; and

16          b. The laboratory test or x-ray is within the scope of the physician assistant's  
17 practice.

18          (2) For an intermediate care facility for individuals with mental retardation or a  
19 developmental disability, an ancillary service shall be a direct service for which a charge  
20 is customarily billed separately from a per diem rate including:

21          (a) Ancillary services identified in 907 KAR 1:023;

22          (b) Laboratory procedures or x-rays if ordered by a:

23          1. Physician;

1           2. An ARNP if the laboratory test or x-ray is within the scope of the ARNP's  
2 practice; or

3           3. Physician assistant if:

4           a. Authorized by the supervising physician; and

5           b. The laboratory test or x-ray is within the scope of the physician assistant's  
6 practice; or

7           (c) Psychological or psychiatric therapy.

8           (3) Ancillary service.

9           (a) Reimbursement shall be subject to a year-end audit, retroactive adjustment,  
10 and final settlement.

11          (b) Costs shall be subject to allowable cost limits pursuant to 42 C.F.R. 413.106.

12          (4) For ancillary services, the department shall utilize an NF's prior year cost-to-  
13 charge ratio, based on the prior year's cost report as of May 31, as the percentage to be  
14 used for interim reimbursement purposes for the following year. (For example if an NF's  
15 cost-to-charge ratio for SFY 2001 is seventy-five (75) percent, the department shall  
16 reimburse the NF, on an interim basis, seventy-five (75) percent of billed charges for  
17 SFY 2002.)

18          (5) An NF without a prior year cost report may submit to the department a  
19 percentage to be used for interim reimbursement purposes for ancillary services.

20          (6) If an NF has been reimbursed for ancillary services at an interim percentage  
21 above its allowable cost-to-charge ratio for a given year, the department shall decrease  
22 the interim percentage for the following year by no more than twenty-five (25)  
23 percentage points unless:

1 (a) A retroactive adjustment of an NF's reimbursement for the prior year reveals  
2 an overpayment by the department exceeding twenty-five (25) percent of billed charges;  
3 or

4 (b) An evaluation of an NF's current billed charges indicates that the NF's  
5 charges exceed, by greater than twenty-five (25) percent, average billed charges for  
6 other comparable facilities serving the same area.

7 Section 6. Reimbursement for a Nursing Facility With a Distinct Part Ventilator  
8 Unit.

9 (1) A nursing facility recognized as providing distinct part ventilator dependent  
10 care shall be paid at an all-inclusive (excluding drugs which shall be reimbursed through  
11 the pharmacy program) fixed rate for services provided in the distinct part ventilator unit.

12 (2) A distinct part ventilator unit shall:

13 (a) Have a minimum of twenty (20) beds;

14 (b) Maintain a census of fifteen (15) patients; and

15 (c) Base the patient census upon:

16 1. The quarter preceding the beginning of the rate year; or

17 2. The quarter preceding the quarter for which certification is requested if the  
18 facility did not qualify for participation as a distinct part ventilator care unit at the  
19 beginning of the rate year.

20 (3)(a) The fixed rate for a hospital-based facility shall be \$583.82 [~~\$568.47~~] per  
21 day.

22 (b) The department shall reimburse a freestanding facility:

23 1. A fixed rate of \$317.29 [~~\$308.95~~] per day; and

1           2. An add-on to the fixed rate in accordance with KRS 142.363.

2           (4) The fixed rates established in subsection (3)(a) of this section shall be  
3 increased or decreased based on the Data Resource Incorporated rate of inflation  
4 indicator for the nursing facility services for each rate year.

5           (5) Costs of distinct part ventilator nursing facility units shall be excluded from  
6 allowable costs for purposes of rate setting and settlement of cost-based nursing facility  
7 cost reports.

8           Section 7. Reimbursement for a Nursing Facility with a Brain Injury Unit.

9           (1) In order to participate in the Medicaid Program as a brain injury provider, a  
10 nursing facility with a distinct part brain injury unit shall:

11           (a) Be Medicare and Medicaid certified;

12           (b) Designate as a brain injury unit at least ten (10) certified beds that are  
13 physically contiguous and identifiable;

14           (c) Be accredited by the Commission on Accreditation of Rehabilitation Facilities  
15 (CARF) after the first year of participation; and

16           (d) Establish written policies regarding administration and operations, the facility's  
17 governing authority, quality assurance, and program evaluation.

18           (2) Except as provided in subsection (3) of this section, a nursing facility with a  
19 Medicaid certified brain injury unit providing preauthorized specialized rehabilitation  
20 services for persons with brain injuries shall be paid at an all-inclusive (excluding drugs  
21 which shall be reimbursed through the pharmacy program) fixed rate which shall be set  
22 at \$360 per diem for services provided in the brain injury unit.

23           (3) A facility providing preauthorized specialized rehabilitation services for

1 persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae  
2 shall be paid an all-inclusive (excluding drugs which shall be reimbursed through the  
3 pharmacy program) negotiated rate which shall not exceed the facility's usual and  
4 customary charges.

5 Section 8. Appeal Rights. A participating facility may appeal department  
6 decisions as to the application of this administrative regulation as it impacts the facility's  
7 reimbursement in accordance with 907 KAR 1:671, Sections 8 and 9.

8 Section 9. Reimbursement for Required Services Under the Preadmission  
9 Screening Resident Review (PASRR) for a Nursing Facility With a Ventilator Unit, a  
10 Nursing Facility With a Brain Injury Unit, an IMD, or a Dually-licensed Pediatric Facility.

11 (1) Prior to an admission of an individual, a facility shall conduct a level I PASRR  
12 in accordance with 907 KAR 1:755, Section 4.

13 (2) The department shall reimburse a facility for a service delivered to an  
14 individual if the facility complies with the requirements of 907 KAR 1:755.

15 (3) Failure to comply with 907 KAR 1:755 may be grounds for termination of a  
16 facility's participation in the Medicaid Program.

17 Section 10. Reimbursement Provisions.

18 (1) Each of the following types of facilities participating in the Medicaid Program  
19 shall be reimbursed in accordance with this administrative regulation:

20 (a) A nursing facility with a certified brain injury unit;

21 (b) A nursing facility with a distinct part ventilator unit;

22 (c) A nursing facility designated as an institution for mental diseases;

23 (d) A dually-licensed pediatric facility; or

1 (e) An intermediate care facility for individuals with mental retardation or a  
2 developmental disability.

3 (2) A payment made to a facility governed by this administrative regulation shall:

4 (a) Be made in accordance with the requirements established in 907 KAR 1:022;  
5 and

6 (b) Be subject to the limits established in 42 C.F.R. 447.272.

7 Section 11. Supplemental Payments to Dually-licensed Pediatric Facilities.

8 (1) Beginning July 1, 2002 and annually thereafter, the department shall establish  
9 a pool of \$550,000 to be distributed to facilities qualifying for supplemental payments in  
10 accordance with subsection (2) of this section.

11 (2) Based upon its pro rata share of Medicaid patient days compared to total  
12 patient days of all qualifying facilities, a dually-licensed pediatric facility shall qualify for  
13 a supplemental payment if:

14 (a) Funding is available; and

15 (b) The facility:

16 1. Is located within the Commonwealth of Kentucky;

17 2. Has a Medicaid occupancy rate at or above eighty-five (85) percent;

18 3. Only provides services to children under age twenty-one (21); and

19 4. Has forty (40) or more licensed beds.

20 (3) A supplemental payment to a facility meeting the criteria established in  
21 subsection (2) of this section shall:

22 (a) Apply to services provided on or after July 1, 2002;

23 (b) Be made on a quarterly basis; and

1 (c) Not be subject to the cost settlement provisions established in Section 3 of  
2 this administrative regulation.

3 Section 12. Incorporation by Reference.

4 (1) The following material is incorporated by reference:

5 (a) "Cost-based Facility Reimbursement Cost Report Instructions", April 2000  
6 Edition; and

7 (b) "Cost-based Facility Reimbursement Cost Report", April 2000 Edition.

8 (2) This material may be inspected, copied, or obtained, subject to applicable  
9 copyright law, at the Department for Medicaid Services, 275 East Main Street, 6th Floor  
10 West, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 1:025E

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Date

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Shannon Turner, J.D., Commissioner  
Department for Medicaid Services

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Date

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Mike Burnside  
Undersecretary for Administrative and Fiscal Affairs

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Date

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James. W. Holsinger, Jr., M.D., Secretary  
Cabinet for Health and Family Services

## REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:025E

Cabinet for Health Services

Department for Medicaid Services

Agency Contact Person: Stuart Owen or Stephanie Brammer-Barnes (564-6204)

- (1) Provide a brief summary of:
  - (a) What this administrative regulation does: This administrative regulation establishes Department for Medicaid Services (DMS) reimbursement for services provided by an intermediate care facility for individuals with mental retardation or a developmental disability (ICF-MR-DD), a dually-licensed pediatric facility, an institution for mental diseases, a nursing facility with an all-inclusive rate unit.
  - (b) The necessity of this administrative regulation: This administrative regulation is necessary to provide for DMS reimbursement for services provided by an ICF-MR-DD, a dually-licensed pediatric facility, an institution for mental diseases, a nursing facility with an all-inclusive rate unit.
  - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of authorizing statutes by establishing DMS reimbursement for services provided by an ICF-MR-DD, a dually-licensed pediatric facility, an institution for mental diseases, a nursing facility with an all-inclusive rate unit.
  - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of statutes by establishing DMS reimbursement for services provided by an ICF-MR-DD, a dually-licensed pediatric facility, an institution for mental diseases, a nursing facility with an all-inclusive rate unit.
- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
  - (a) How the amendment will change this existing administrative regulation: The amendments to this administrative regulation increase reimbursement for ICF-MR-DDs in order to enhance recipient access to ICF-MR-DD services and enables DMS to adjust a facility's reimbursement if it experiences a mandated displacement of residents.
  - (b) The necessity of the amendment to this administrative regulation: The amendments to this administrative regulation are necessary in order to enhance recipient access to ICF-MR-DD services. DMS is witnessing decreasing bed occupancy in institutions as a result of an increasing emphasis on community placement and the growth of the Supports for Community Living (SCL) program.
  - (c) How the amendment conforms to the content of the authorizing statutes: The amendments to this administrative regulation conform to the content of the authorizing statutes by enhancing recipient access to ICF-MR-DD services and

- by enabling DMS to adjust a facility's reimbursement if it experiences a mandated displacement of residents.
- (d) How the amendment will assist in the effective administration of the statutes: The amendments to this administrative regulation will assist in the effective administration of the statutes by increasing reimbursement for ICF-MR-DDs in order to enhance recipient access to ICF-MR-DD services and by enabling DMS to adjust a facility's reimbursement if it experiences a mandated displacement of residents.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: There are currently thirteen (13) - ten (10) state-owned and three (3) privately-owned – ICF-MR-DDs, participating in the Medicaid Program.
- (4) Provide an assessment of how the above group or groups will be impacted by either the implementation of this administrative regulation, if new, or by the change if it is an amendment: As a result of the amendments to this administrative regulation, ICF MR DDs shall receive an increase in reimbursement in order to enhance recipient access to services and any facility that experiences a mandated displacement of residents may have its rate adjusted.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
- (a) Initially: DMS anticipates that this action will annually generate \$4.095 million for the Medical Assistance Revolving Trust (MART) Fund. The \$4.095 million MART fund money plus federal matching funds are expected to generate an annual total of \$13.8 million of which \$8.095 (the original \$4.095 million plus an additional \$4.0 million) will be returned to participating ICF-MR-DDs. DMS would keep the remainder (over \$5.7 million.) DMS is unable to predict the fiscal impact of the amendment enabling it to adjust a facility's rate if it experiences a mandated displacement of residents.
- (b) On a continuing basis: DMS anticipates that this action will annually generate \$4.095 million for the MART Fund. The \$4.095 million MART fund money plus federal matching funds are expected to generate an annual total of \$13.8 million of which \$8.095 (the original \$4.095 million plus an additional \$4.0 million) will be returned to participating ICF-MR-DDs. DMS would keep the remainder (over \$5.7 million.) DMS is unable to predict the fiscal impact of the amendment enabling it to adjust a facility's rate if it experiences a mandated displacement of residents.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Federal funds authorized under Title XIX and Title XXI of the Social Security Act, state matching funds, and MART funds in accordance with KRS 142.363 shall be used to implement the amendment to this administrative regulation.

- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: funding to implement the amendment to this administrative regulation will be provided by the MART Fund in accordance with KRS 142.363.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: this administrative regulation does not establish any fees nor directly or indirectly increase any fees.
- (9) Tiering: Is tiering applied? Tiering was utilized due to the fact that KRS 142.363 mandated that ICF MR DDs be given an increase in reimbursement in order to offset a provider assessment increase. The assessment increase was not levied against other provider types governed by this administrative regulation.

## FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:025E

Agency Contact: Stuart Owen or  
Stephanie Brammer-Barnes (564-  
6204)

### 1. Federal statute or regulation constituting the federal mandate.

Pursuant to 42 USC 1396a et. seq., the Commonwealth of Kentucky has exercised the option to establish a Medicaid Program for indigent Kentuckians. Having elected to offer Medicaid coverage, the state must comply with federal requirements contained in 42 USC 1396 et. seq.

### 2. State compliance standards.

The amendment to this administrative regulation increases reimbursement for intermediate care facilities for individuals with mental retardation or a developmental disability (ICF-MR-DD) in order to enhance recipient access to ICF-MR-DD services and enables the Department for Medicaid Services (DMS) to adjust a facility's rate if it experiences a mandated displacement of residents.

### 3. Minimum or uniform standards contained in the federal mandate.

The amendment to this administrative regulation increases reimbursement for intermediate care facilities for individuals with mental retardation or a developmental disability (ICF-MR-DD) in order to enhance recipient access to ICF-MR-DD services and enables the Department for Medicaid Services (DMS) to adjust a facility's rate if it experiences a mandated displacement of residents.

### 4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?

This administrative regulation does not set stricter requirements.

### 5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.

No additional standard or responsibilities are imposed.